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AUTHOR Jones, Edlyn N.; Lancaster, Julie
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ABSTRACT

Acquired Immune Deficiency Syndrome is becoming the United States' primary health and psychological crisis. While many populations are at risk for infection, college and university students, because of unsafe sexual behaviors, experimentation with alcohol and drugs, and failure to see themselves at risk for infection, are particularly vulnerable to this disease. This article is directed toward college and university counselors, who are often in the forefront for helping individuals deal with the disease and its implications. It summarizes the research literature on ways to respond to the potential crisis. Because colleges contain large concentrations of sexually active young people, they will have to shape policy regarding HIV-positive students on campuses. It is recommended that college counselors acquire and maintain a thorough understanding of HIV disease and AIDS, understand risk behaviors and society's reactions to them, acquire an understanding of common neurological and psychological reactions, and recognize and work through HIV/AIDS-elicited attitudes, reactions, and feelings. Recommendations for HIV preventative education and intervention considerations when working with individuals affected by HIV disease are also offered. Institutions of higher learning can be prepared for problems related to an HIV/AIDS epidemic by having personnel prepared with information and procedures. Contains 43 references. (RJM)

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What College Counselors Need To Know
About HIV Disease: Some Recommendations from the Literature

Edlyn N. Jones

Assistant Professor

School of Education

Indiana University Purdue University Fort Wayne

Julie Lancaster

Outpatient Therapist

The Bowen Center

Huntington, Indiana

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Running Head: College Counselors and HIV Disease

Abstract

College students are at increasing risk for HIV disease due to unsafe sexual practices, experimentation with alcohol and drugs, and failure to see themselves at risk for infection. The research literature appears grim in its assessment and prediction of the increasing spread of HIV disease on college and university campuses. As environments containing large concentrations of sexually active young people, colleges and universities will have to shape policy regarding HIV-positive students on the campuses as the threat of HIV infection becomes greater. This article is directed toward college and university counselors, who are often in the forefront for helping individuals deal with the disease and its implications, and summarizes the research literature on ways to respond to the potential crisis. Recommendations for HIV preventative education and intervention considerations when working with individuals affected by HIV disease are also offered.

What College Counselors Need To Know

About HIV Disease: Some Recommendations from the Literature

Introduction

The epidemic of Acquired Immune Deficiency Syndrome (AIDS) is becoming the nation's primary health and psychological crisis (Hoffman, 1991). While many populations are at risk for infection, one population is emerging for which the Human Immunodeficiency Virus (HIV) has become a major health threat: that population is college and university students (Shulkin et al., 1991). Studies have indicated that young, sexually active people in colleges and universities often practice unsafe sexual behaviors (e.g., do not use condoms and/or have multiple sexual partners), experiment with alcohol and drugs, and fail to see themselves at risk for infection, thus making themselves vulnerable to the spread of HIV disease (Butcher, Manning & O'Neal, 1991; House & Walker, 1993; Innes & Ahrens, 1990; Shulkin et al., 1991; Stiff, McCormack, Zook, Stein, & Henry, 1990). Moreover, sexually transmitted diseases on college campuses are reported to have increased at an alarming rate, further indicating that the college and university populations are probably not practicing safer sex (Douce, 1993).

The research literature appears grim in its assessment and prediction of the increasing spread of HIV disease on college and university campuses. This article is directed toward college and university counselors, who are often in the forefront for

helping individuals deal with the disease and its implications, and summarizes the research literature on ways to respond to the potential crisis. The epidemic of HIV disease requires counselors to be current with facts that will provide culturally-relevant, behavior-changing education. HIV infection has created a need to anticipate and prepare for a multitude of situations. In the course of the epidemic, students with HIV infection will continue to enroll and be employed at colleges and universities, and they will have special counseling needs. In addition, the disease will impact significant others, family, and friends in varying ways (Douce, 1993).

Preparing to address these situations and for making difficult decisions related to HIV infection and AIDS on campuses is key. The information and strategies needed for college and university helping professionals are applicable to anyone involved in the treatment and prevention of HIV disease and most information presented is directed at campuses with a full range of student services, usually residential campuses. For many others, e.g., commuter campuses, college student personnel may adapt these recommendations for those personnel at their institutions responsible for these student services.

Overview

The current rate of HIV infection among college and university students is approximately two student per 1000 (Gamba, 1990; Keeling, 1993), with some estimations that the rate is closer to three infected students per 1000 (Blonna, Hayden & Milcetic, 1991). Furthermore, there appears to be a higher prevalence of HIV

infection (about 10 per 1000) at campuses located close to communities with high local prevalence of infection (Keeling, 1993). Traditional college-age students between the ages of 19 and 24 represent about 20 percent of the present cases among 20 to 29 year olds (Carney, Baroway, Perkins, Pousson, & Whipple, 1991; House & Walker, 1993; Loos & Bowd, 1989; Stiff et al., 1990). The age at which individuals are first experiencing symptoms of HIV infection is decreasing (Loos & Bowd, 1989). As more individuals are being diagnosed in their twenties, it is likely the onset of the disease probably occurred during late adolescence (Butcher et al., 1991; Douce, 1993; Hernandez & Smith, 1990; House & Walker, 1993), and increasing rates of diagnosis with HIV are predicted for this age group (Blonna et al., 1991). Sexually active college and university students often do not use contraception or condoms, which places them at risk not only for HIV infection, but for sexually transmitted diseases and unwanted pregnancies as well (Blonna, Hayden & Milcetic, 1991; Stiff et al., 1990).

Compared to current estimations of cases of diagnosed AIDS (exclusive of HIV-positive infected individuals) in the U.S., relatively few cases of HIV disease have been reported among the vast number of college and university students (Blonna et al., 1991; Butcher et al., 1991). The increasing spread of HIV and sexually transmitted diseases on college campuses appears to be related to several factors: high risk sexual behavior, lack of accurate information, and resistance to changing risky sexual behaviors. Sexually active young people who are either having sex with multiple partners without condoms or who are reluctant to use condoms with a single

partner appear to be at the greatest risk for contracting HIV (Butcher et al., 1991; Bruce, Shrum, Trefethen & Slovik, 1990; Carney et al., 1991; DiClemente, Forrest, & Mickler, 1990; Gamba, 1990; Thurman & Franklin, 1990; Wilson, Manual & Lavelle, 1991). Students tend to underestimate their own risk of contracting HIV and may be compromising their health by failing to reduce high risk sexual behavior (Crawford, 1990; Thurman & Franklin, 1990). Possible causes for that high risk sexual behavior included partners' failing to communicate about contraception, partners' being intolerant of or embarrassed about using condoms, and partners' being unprepared (eg. failing to carry condoms) or having personal values or culture-specific practices that limit condom use (Bruce et al., 1990; Goertzel & Bluebond-Langner, 1991; Loos & Bowd, 1989; Wilson et al., 1991).

There are also indications that substance use and abuse on college and university campuses have contributed to the increasing risk for HIV and other sexually transmitted diseases (Shulkin et al., 1991). Studies have revealed a relationship between substance use and lower sexual inhibitions, indicating that many students may consent to sexual intercourse while intoxicated (Shulkin et al., 1991; Butcher et al., 1991); therefore alcohol and drugs may contribute directly to the acquisition or transmission of HIV infection. Temple and Leigh (1992), however, found no significant relationship between use of alcohol and the occurrence of intercourse or use of condoms or other methods of protection among adults, in contrast to studies of adolescents. They suggested that certain attitudinal or personality characteristics are

stronger predictors of unsafe sex. DiClemente et al. (1990) and Hernandez and Smith (1990) concurred that not only increased substance use and sexual experimentation increase HIV risk, but other factors such as increased autonomy from parents' rules and accelerated personal, social, and intellectual development play a part in students' attitudes and behaviors.

Lack of knowledge about the disease, and misconceptions about HIV infection and AIDS may also increase risk on college and university campuses (Bruce et al., 1990; DiClemente et al., 1990). Education is necessary to provide the insight and understanding necessary to change young peoples' attitudes about HIV disease (Shulkin et al., 1991; Stevenson & Stevenson, 1990; and Stiff et al., 1990). Campus administrations struggle over exactly what messages to deliver and how to get the messages across.

While much prevention information is available on campuses, students are not necessarily changing their sexual practices. Many studies conducted have been based on self-report inventories, which makes them vulnerable to bias. Respondents' disclosures could be either minimized or exaggerated, and there may be inconsistencies that do not allow a true picture to be presented. Also, the samples described were often small and not randomized, leading to an inability to generalize to whole populations. Future research may need to address some of these inadequacies.

Personal responsibility on the part of young people is also necessary to keep the epidemic from spreading (Carney et al., 1991; Goertzel & Bluebond-Langner, 1991; Loos & Bowd, 1989). Resistance to changing their sexual behaviors in light of the knowledge of risk of infection appears to be a significant factor in the increasing risk of HIV infection in young people. Knowledge of HIV/AIDS transmission has not significantly changed the sexual behaviors of many at-risk individuals. Reluctance to change may be attributed to young peoples' feelings of invincibility, invulnerability, and perceived insusceptibility to the disease (Bruce et al., 1990; Butcher et al., 1991; Crawford, 1990; DiClemente et al., 1990; Dworkin & Pincus, 1993; Goertzel & Bluebond-Langner, 1991; Fan & Shaffer, 1990; Lipson & Brown, 1991; Hernandez & Smith, 1990; Loos & Bowd, 1989; Thurman & Franklin, 1990). Individuals apparently use a mechanism to separate personal meaning from external reality, and thus they are able to know about the potential risk of acquiring or transmitting HIV disease, but not feel threatened or motivated to change behavior. However when students are actually impacted by HIV/AIDS awareness, they may change their sexual behavior by merely modifying it, such as reducing the number of sexual partners (Widen, 1987).

Education

"Counselors and other human development professionals can and perhaps should be in the forefront of providing HIV and AIDS prevention education" (Croteau, Nero & Prosser, 1993, p. 294). Issues of personal development and relationship issues, regardless of sexual orientation, are commonly presented in college counseling

centers. Furthermore, college counseling centers and related university personnel (e.g., health services) provide psychoeducational/informational group counseling services and other outreach services to campus organizations such as residence halls, and fraternities and sororities, making available a venue for providing accurate and comprehensive HIV and AIDS information. Loos and Bowd (1989) and DiClemente et al. (1990) have reported that students desire and need HIV information, need programs for AIDS prevention, and need help to dispel misconceptions. Students have relied on the media for information on the disease and it will be the counselor's job to present accurate, complete and scholarly information, information that may be different from that which the media presents on health issues (Carney et al., 1991). Thus it is imperative that counselors remain up-to-date themselves with current information and terminology related to HIV and AIDS.

Counselors, along with other university personnel, need to assess particular attitudes among students in order to determine information deficits. Those deficits may include students' inability or unwillingness to discuss HIV or other sexually transmitted diseases with partners before intercourse and students' concept of invulnerability. Misconceptions about HIV infections also involve use of condoms, number of sexual partners, and kinds of intercourse (DiClemente et al., 1990). Counselors need to examine perceptions of invulnerability to infection and the consequent reluctance to change risky behaviors (Hayes, 1991; Loos & Bowd, 1989; O'Leary, Goodhart, Jemmott, & Boccher-Lattimore, 1992).

AIDS prevention programs can be implemented when counselors have assessed sexual practices, other risk-taking behaviors, attitudes, and concerns of college and university populations. Since there may be discrepancies between what students report they know and what they actually know, the discrepancies will have to be explored (Crawford, 1990; Gamba, 1990). Ideally, the knowledge of HIV and concern about getting the disease will produce a change in risky sexual behaviors. However, studies by Crawford (1990), Gamba (1990), and Thurman and Franklin (1990) have all indicated that many students' increased knowledge of HIV high risk behavior has not yet led to a change in their behaviors. Emmons et al. (1986) reported that AIDS-related behavior change was positively associated with knowledge about AIDS, perceived self-risk of acquiring the HIV infection, perceived efficacy of behavior change, and social norms supportive of behavior change. The latter is most likely to be an effective target for implementing behavior change among college students and should be examined in developing education and prevention programs (Hayes, 1991; O'Leary, et al., 1992).

As noted earlier, when students are actually impacted by HIV/AIDS through personal experience of a family member or friend infected with HIV or through exposure to persons with AIDS, this may result in behavior changes. Panel discussions in selected courses or student organizations and other campus-wide presentations with invited speakers who are HIV infected or diagnosed with AIDS may increase this awareness and personal vulnerability. These activities can also be

incorporated in campus events such as health fairs or "alcohol and drug awareness week", events frequently used on campuses today to promote preventative health care.

Included in preventative HIV education should be sex education (including physiological as well as moral and ethical concerns), emotional reactions to one's sexuality, contraception, HIV disease and AIDS, and sexual practices. Specifics of the disease, such as transmission routes, i.e., through blood, semen, and breast milk, the ways HIV affects the immune system, and HIV-related syndromes should be addressed (Stiff et al., 1990). Education directed to persons with HIV disease would include teaching and encouraging prevention measures, such as not donating blood, semen, ova or body organs, practicing safer sex at all times (e.g., using latex condoms and water-based lubricants, having sex with only one mutually committed uninfected partner), not sharing unclean injection equipment or personal items such as razors or toothbrushes, and informing their sexual or drug-using partners of their risk for infection (Chateauvert, Duffie, & Gilmore, 1991).

A prevention program could also include extensive condom distribution and instruction in use, expanded STD diagnostic and treatment services, substance use education including its impact on sexual behavior, and rehabilitation for student abusers. Exploration of personal beliefs and values, acceptance versus tolerance of diversity, sexual orientation, and "safer sex" practices should also be included in educational programs. Programs addressing self-esteem, self-respect, values

clarification, decision-making, assertiveness, and intimacy versus sexuality are also key to prevention. The goal of such programs is to empower individuals. Indeed, such empowering education may be the most effective way to help students accept personal responsibility and thus help reduce their risk of acquiring HIV disease (Blonna et al., 1991; Butcher et al., 1991, Dworkin & Pincu, 1993).

Psychosocial Implications

College and university counselors need to be familiar with the psychosocial aspects of the disease. Reactions to an HIV positive diagnosis are similar to reactions to other terminal diseases. There may be denial, disbelief, despair, shock, emptiness, a general sense of loss, overriding sense of gloom, phobic reactions including fear of death and dying, fear of exposure of lifestyle, fear of loss of physical attractiveness or disfigurement, and concern over treatment options. Suicidal ideation and sexual dysfunction may also be present, as well as fear of abandonment and guilt or self-blame (Curtis, 1989; Dworkin & Pincu, 1993). While there are these similarities in reactions with other terminal illnesses, counselors need to be aware of, and respond to, neurological and psychosocial factors specific to HIV disease and AIDS, e.g., depression, AIDS dementia complex, and social stigmatization and discrimination (Knapp, S. & VandeCreek, L., 1990; Werth, J. L., 1993).

Widen (1987) suggested some specific steps in using a psycho-educational counseling approach in working with HIV disease-infected clients. The steps would

include "forming an alliance," "working through the integration of learning," and "supporting cognitive restructuring and behavior change" (Widen, 1987, p. 269). Curtis (1989) offered other guidelines for counseling these same clients: (a) engaging in honest unforced discussion about the illness with guidelines for risk reduction, (b) structuring issues that the client needs to face, (c) getting agreement on tasks to be done, e.g., informing intimates of the illness, (d) assisting the client in getting a sense of control over his or her life, (e) providing opportunities to work through feelings at different physical and psychological stages of the illness, and (f) managing anxiety, depression and stress.

The overall impact of an HIV positive diagnosis may result in shock, feelings of anger and powerlessness, and reduced physical, cognitive and sexual functioning (Dworkin & Pincu 1993). There may be fears of infecting others and of being deserted, as well as fear of social, domestic, and occupational disruption (Curtis, 1989; Dworkin & Pincu, 1993). Counselors at college and university counseling centers may be faced with HIV disease-infected students and staff who have varying psychosocial needs and may be at different stages in the disease (Douce, 1993). In the early stages of HIV infection there may be psychological symptoms such as insomnia, anxiety, and depression, in addition to feeling a loss of a sense of predictability and certainty about the future. With this in mind, counselors need to work with individuals to reappraise goals, academic programs, careers, and relationships. In the early stages, the person with HIV disease may have a great deal

of fear and may worry about physical symptoms that will appear later on (Keeling, 1993).

Rosser and Ross (1991) have reported that some individuals with HIV disease seek counseling late in the disease for many reasons, including denial, not perceiving themselves at risk, or thinking it is too late to do anything about it. These individuals may have neurological conditions and psychotic complications as well as depression and a reluctance to face the situation. Counselors may need to address the issue of resistance in these individuals, and be aware that it can affect the counseling process.

Another important aspect of counseling those affected by HIV disease is knowledge of the grieving process (Strader, 1993). There is much anticipatory grief over losses, including loss of life goals, expectations, loss of relationships, and loss of prior functioning. The younger age associated with death from AIDS needs to be considered, as well as the individual's sense of isolation and abandonment. The grieving process will have unique aspects for each individual affected by HIV disease (Strader, 1993). Treatment requires multiple interventions over the course of the disease, beginning with early diagnosis and monitoring of the disease. Interventions should include involving the infected person in making decisions about disease management; offering medical and health care information, psychological, and/or rehabilitative interventions; and assisting with social, legal, ethical, and spiritual issues (Chateauvert et al., 1991; Keeling, 1993).

Stevenson and Stevenson (1990) stressed the importance of counseling programs on campuses and the inclusion of other college and university personnel, such as advisors and faculty, to meet the variety of problems related to HIV disease. Curtis (1989) and Strader (1993) advocated that counselors work in multidisciplinary teams with doctors and the client's significant others, and recommended that a working relationship should be established between the counselor and physician. Counselors will have to know related physical and psychiatric conditions of HIV symptoms in order to refer the client if he/she evidences changes in behavior (Dworkin & Pincu, 1993). College information providers will want to use professional organizations to distribute the most accurate information and need to consider the attitudes of students and faculty concerning HIV positive persons on campuses (Carney et al., 1991).

Developmental issues also need to be considered in counseling individuals with HIV disease on college and university campuses. Erikson (1968), in his stages of human development, indicated that intimacy and generativity are the typical stages of development for individuals aged twenty and older. Both of these developmental issues need to be addressed in light of an HIV positive diagnosis. Dworkin and Pincu (1993) have reported that college students may need to deal with issues of personal and social identity. Other important concepts such as self-esteem, decisions about treatment of the disease, quality of life concerns, and preparation for death may need to be addressed as well.

In addition to these psychosocial aspects of the disease, the counselor needs to understand the connection between psychosocial factors and their impact on biological changes. For example, a crisis could cause anxiety, which could further impair the immune system and increase progression of the disease (Dworkin & Pincu, 1993). Stress can further compromise the immune system, causing physical problems even in people with healthy immune systems. Counselors must help individuals infected with HIV acknowledge their experience of a greater number of stressful events in close proximity to one another, such as experiencing the death of a life partner or close friend, having a personal injury or illness, being fired at work, experiencing a change in financial status and/or living conditions (Werth, 1993) and aid in coping with these stressors. Emotional support plays an important part in the overall adjustment of HIV-infected individuals. Low support is seen as negative, and high support seems to indicate better adjustment and fewer symptoms in the patient. Including significant others in the overall treatment plan can be important in promoting more positive adjustment for the HIV patient (Strader, 1993).

Counselor Attitude and Values

Rosser and Ross (1991) and Dworkin and Pincu (1993) have recommended that counselors evaluate themselves to determine their own attitudes and values towards those affected by HIV disease. Counselors must be sensitive to the association of the disease with death, and understand what roles stigmatization and discrimination play in the patient's ability to ask for and receive care. Counselors'

values on topics such as homophobia, drug use, sexuality, HIV testing, confidentiality, death and dying, and the idea of rational suicide are among those values to be examined, which may impact their ability to deal with those affected by the disease. Counselors' knowledge of the disease and their ability to process the affect of those who are ill will be vital components in the counseling process (Dworkin & Pincu, 1993).

Counselors treating HIV positive individuals may have special responsibilities imposed on them by the nature of the illness. The warmth and caring of the counselor and the ability to be flexible can not be emphasized enough (Triggs & McDermott, 1991). Although it is typical for counselors to make commitments to their clients and respond in a nonjudgmental way, Strader (1993) contended that counselors may need to commit to HIV disease-infected individuals to maintain the therapeutic relationship throughout the course of treatment. Clients will need assurances that the relationship will be on-going, and that counselors will have the potential for adjustment to clients' changing needs.

Counselors must also have the ability to meet the needs of the caregivers and significant others of HIV clients. Among the issues experienced by this group are loss of objectivity, feelings of anger, hopelessness and despair, a need for distance from the pain, and low self-esteem.

Counselors also need to care for themselves. Sources of support will be necessary for them, as well as coping skills to deal with the stressful work of counseling clients affected by HIV disease (Dworkin & Pincu, 1993; Jackson, 1993).

Counselors working with these individuals may experience frustration and helplessness, and may find themselves involved in their own grieving process; the psychological effects on and resulting psychological needs of counselors working with this population is likely under-recognized and under-researched (Mejta, 1987).

Other Related Information

Other related information addressing HIV disease can be divided into the following areas: cultural issues, testing, confidentiality, and policy. Strader (1993) emphasized a culturally-sensitive approach to counseling. Behavioral and attitudinal barriers need to be overcome in order to provide effective intervention in HIV disease prevention. Thomas, Gilliam, and Iwrey (1989) noted that dispelling negative misinformation and examining culture-specific sexual practices is a role of counselors. With the disproportionate impact of HIV infection in ethnic and racial groups, there is a need to reach these groups with effective risk-reducing programs.

Focus should be placed on risk behaviors and not the risk groups in order that the social and cultural context of individuals with HIV disease can be addressed (Croteau et al., 1990). Counselors need to create a partnership with social and cultural experts from the groups that are affected. By being aware of the prejudicial beliefs about HIV disease, the counselor will understand and be able to deal with misconceptions and will understand how some infected individuals face the added difficulty of discrimination and stigmatization. This includes an awareness and responsiveness to current HIV-related semantics, such as referring to person(s)/people

with AIDS or PWAs rather than "AIDS victims", and reference to the HIV antibody test rather than "AIDS test" (Werth, 1993).

Keeling (1986) indicated that while HIV testing was originally devised to screen donated blood, it is currently useful in other ways. The results of testing can provide motivation for behavior change, especially when early interventions in the illness can be very beneficial. When results are negative, anxiety will be relieved. Positive results will help guide the counseling that is needed. Testing can be helpful in new relationships to protect the health of both partners. Furthermore, testing can be vital for women who want to make informed decisions about existing or future pregnancies. However, the whole issue of testing is very complex and personal, and there are no blanket recommendations that can or should be made regarding whether or not to test for HIV (Keeling, 1986). Chateauvert et al. (1991) have recommended that assessment for HIV include a complete sexual history. Counseling before and after testing is also recommended.

Ethical considerations are, of course, an important aspect of the counseling process. Confidentiality and informed consent are critical issues in HIV risk assessment and counseling (Rosser & Ross, 1991). There are arguments for and against disclosure of the disease and again, no blanket recommendations can be made about disclosure of HIV status because of the highly complicated and personal issues involved (Strader, 1993). Werth (1993) noted that the APA Ad Hoc Committee on Psychology and AIDS, in 1991, developed a statement to help guide practitioners'

decision-making that supports professional judgment to be made by the provider on a case-by-case basis. Because limits of confidentiality have not been defined for the dilemma of a seropositive individual who continues to be sexually active without informing his or her partner(s), counselors need to take proscribed steps in handling the dilemma of confidentiality limits (Gray & Harding, 1988).

As environments containing large concentrations of sexually active young people, colleges and universities will have to shape policy regarding HIV-positive students on the campuses as the threat of HIV infection becomes greater (McClain & Matteoli, 1989). Policy establishing programs and services available will impact how individuals with HIV disease are accommodated and provided for in the academic system. Policy will be needed to determine the limits of accommodation, protective procedures, confidentiality and right to privacy, physical and mental health services, and financial and academic assistance.

Summary and Recommendations

The literature offers much that is useful to college and university counselors for the anticipation of and preparation of services that will be valuable in dealing with the increasing risk of HIV disease on campuses. Clearly, counselors at institutions of higher learning occupy an important role in the task of educating and assisting individuals. With no cure for HIV disease, prevention remains the key in controlling the epidemic; education is a key component in prevention efforts. Studies have shown that education alone is not enough, however, and health care providers,

educators, and mental health professionals, including college/university counselors and university administrations have the challenge of finding the most effective way to get an additional message across. That message is that prevention of HIV disease can be achieved through individuals' taking personal responsibility to protect themselves.

Few professional counselors have received training to respond effectively to the varied and complex issues specifically related to HIV disease and AIDS, nor have college counselors been faced with such profound examinations of life and death (Triggs & McDermott, 1991). As the spread of HIV disease escalates on college campuses, it is imperative that counselors (a) acquire and maintain a thorough understanding of HIV disease and AIDS, (b) understand risk behaviors and society's reactions to them, (c) acquire an understanding of common neurological and psychological reactions, while recognizing individual differences, and (d) recognize and work through HIV/AIDS-elicited attitudes, reactions, and feelings (Mejta, 1987).

The research literature provides an overview of the potential for major health problems related to HIV disease on college and university campuses. Knowledge of the potential problems can help initiate steps to be taken at such institutions to anticipate and prepare a course of action. Health care teams on campuses may be used to assess the degree of behavior change and its impact on the course of the disease. On-going research to evaluate behavior change will be an integral part in the development and implementation of HIV prevention programs designed to reduce the

risk of infection among college students (DiClemente et al., 1990; Hayes, 1991; O'Leary et al., 1992).

Along with further research and extensive preventative programs, institutions of higher learning can be prepared for problems related to an HIV/AIDS epidemic by having personnel prepared with information and procedures. Counselors in college and university counseling centers may be the ideal resource to have ready the information and interventions for working with individuals affected by HIV disease. A counseling reference containing specific information and strategies for working with individuals in academic settings could be developed. The counseling reference should address a continuum of needs for students and staff who may be affected by HIV disease as relevant to the specific institution and community environment and resources. Beginning with those who worry about contracting the disease to those who have been diagnosed with AIDS, the counseling reference should outline step by step procedures for providing for the many needs of the individuals who seek help. The reference should address individual and family counseling approaches, and should cover preventative education, psychosocial issues, testing, confidentiality, grief and loss counseling, ethics, and university policy. Community resources and referral sources for legal information, medical insurance, and eligibility for government benefits should be identified and an extensive bibliography should be included.

Institutions of higher education serve as important resources in our society for preventing the spread of HIV disease. While attention in this review has been given to

addressing prevention efforts for the traditional college student, nontraditional students would, of course, benefit from the same efforts. For non-residential, or smaller residential campuses, these recommendations can be assumed by other student personnel services for implementation when counseling center services are limited or non-existent.

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